		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041574

Facility Name: MATTOON HEALTH CARE CENTER

Address: 2121 S. NINTH STREET (Number) MATTOON (City) 61938 (Zip Code)

County: COLE

Telephone Number: (217) 235-7138 **Fax #** (217) 235-7140

IDPA ID Number: 431588535008

Date of Initial License for Current Owners: 03/08/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: M.Gearheart-Financial/K. Herman CR **Telephone Number:** (678) 296-4486/(770) 619-0866 ext. 253

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from MAY 1, 1999 to APRIL 30, 2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Kathy Herman, Senior Reimbursement Analyst
(Firm Name & Address) HEALTHPRIME, 950 North Pointe Pwky, St. 100 Alpharetta
(Telephone) (770) 619-0866 Fax # (770) 619-0262

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: MAY 1, 1999 Ending: APRIL 30, 2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	197,444	10,509	15,886	223,839		223,839		223,839			1
2	Food Purchase		201,151		201,151	(1,667)	199,484	(7,573)	191,911			2
3	Housekeeping	80,338	22,066	274	102,678		102,678		102,678			3
4	Laundry	50,491	21,305		71,796		71,796		71,796			4
5	Heat and Other Utilities			124,060	124,060		124,060	(1,930)	122,130			5
6	Maintenance	36,483	146	26,381	63,010		63,010		63,010			6
7	Other (specify):* Waste Disposal			8,890	8,890		8,890		8,890			7
8	**TOTAL General Services**	364,756	255,177	175,491	795,424	(1,667)	793,757	(9,503)	784,254			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	1,289,510	72,250	83,684	1,445,444	3,568	1,449,012		1,449,012			10
10a	Therapy	27,712	363	477,167	505,242		505,242		505,242			10a
11	Activities	34,156	1,376	4,940	40,472		40,472		40,472			11
12	Social Services	35,064	189	2,009	37,262		37,262		37,262			12
13	Nurse Aide Training	7,905			7,905		7,905		7,905			13
14	Program Transportation			8,554	8,554		8,554	(1,090)	7,464			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,394,347	74,178	585,354	2,053,879	3,568	2,057,447	(1,090)	2,056,357			16
	C. General Administration											
17	Administrative	49,849		416,060	465,909	(7,250)	458,659	(272,845)	185,814			17
18	Directors Fees											18
19	Professional Services			7,239	7,239		7,239	19,352	26,591			19
20	Dues, Fees, Subscriptions & Promotions			29,712	29,712		29,712	(5,099)	24,613			20
21	Clerical & General Office Expenses	78,539	17,730	43,994	140,263	3,682	143,945	41,810	185,755			21
22	Employee Benefits & Payroll Taxes			455,508	455,508		455,508	22,146	477,654			22
23	Inservice Training & Education			483	483		483	96	579			23
24	Travel and Seminar			21,681	21,681		21,681	27,833	49,514			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			54,690	54,690		54,690	188	54,878			26
27	Other (specify):*											27
28	**TOTAL General Administration**	128,388	17,730	1,029,367	1,175,485	(3,568)	1,171,917	(166,519)	1,005,398			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,887,491	347,085	1,790,212	4,024,788	(1,667)	4,023,121	(177,112)	3,846,009			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: MAY 1, 1999 Ending:APRIL 30, 2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	18	Skilled (SNF)	18	6,588	1
2		Skilled Pediatric (SNF/PED)			2
3	130	Intermediate (ICF)	130	47,580	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	148	TOTALS	148	54,168	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,916	101	4,270	6,287	8
9	SNF/PED					9
10	ICF	24,920	12,884	320	38,124	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,836	12,985	4,590	44,411	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.99%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
MEALS

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/08/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/08/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 18 and days of care provided 3,326

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: APRIL 30 Fiscal Year: APRIL 30

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MATTOON HEALTH CARE CENTER #0041574 Report Period Beginning: MAY 1, 1999 Ending: APRIL 30, 2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			248,433	248,433		248,433	6,776	255,209			30
31	Amortization of Pre-Op. & Org.			67,922	67,922		67,922		67,922			31
32	Interest			739,987	739,987		739,987	1,558	741,545			32
33	Real Estate Taxes			66,297	66,297		66,297	84	66,381			33
34	Rent-Facility & Grounds							12,453	12,453			34
35	Rent-Equipment & Vehicles			16,607	16,607		16,607	2,578	19,185			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,139,246	1,139,246		1,139,246	23,449	1,162,695			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		205,740	15,061	220,801		220,801		220,801			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops					1,667	1,667	(1,667)				41
42	Provider Participation Fee			81,030	81,030		81,030		81,030			42
43	Other (specify):* Lab			5,073	5,073		5,073		5,073			43
44	**TOTAL Special Cost Centers**		205,740	101,164	306,904	1,667	308,571	(1,667)	306,904			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,887,491	552,825	3,030,622	5,470,938		5,470,938	(155,330)	5,315,608			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: MAY 1, 1999 Ending: APRIL 30, 2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,640)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,930)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,933)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	424	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(5,677)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Misc	(5,494)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (20,250)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(135,080)	Home Offi	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (135,080)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (155,330)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops	x		1,667	2	40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$ 1,667		47

STATE OF ILLINOIS

MATTOON HEALTH CARE CENTER

ID# 0041574

Report Period Beginning: MAY 1, 1999

Ending: APRIL 30, 2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12	Dial a Ride Revenue	(1,090)	14	12
13	Vending Revenue	(1,667)	41	13
14	Rental Revenue	(225)	35	14
15	Other Rev, HPSI Fees	(405)	20	15
16	Other Revenue	(1,425)	21	16
17	Bank Service Charges	(589)	21	17
18	Marketing - Printing	(93)	21	18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
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77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(5,494)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MATTOON HEALTH CARE CENTER **#** 0041574 **Report Period Beginning:** MAY 1, 1999 **Ending:** APRIL 30, 2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(7,573)	0	0	0	0	0	0	0	0	0	0	(7,573)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(1,930)	0	0	0	0	0	0	0	0	0	0	(1,930)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(9,503)	0	0	0	0	0	0	0	0	0	0	(9,503)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(1,090)	0	0	0	0	0	0	0	0	0	0	(1,090)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(1,090)	0	0	0	0	0	0	0	0	0	0	(1,090)	16
	C. General Administration													
17	Administrative	0	(272,845)	0	0	0	0	0	0	0	0	0	(272,845)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	19,352	0	0	0	0	0	0	0	0	0	19,352	19
20	Fees, Subscriptions & Promotions	(6,082)	983	0	0	0	0	0	0	0	0	0	(5,099)	20
21	Clerical & General Office Expenses	(1,683)	43,493	0	0	0	0	0	0	0	0	0	41,810	21
22	Employee Benefits & Payroll Taxes	0	22,146	0	0	0	0	0	0	0	0	0	22,146	22
23	Inservice Training & Education	0	96	0	0	0	0	0	0	0	0	0	96	23
24	Travel and Seminar	0	27,833	0	0	0	0	0	0	0	0	0	27,833	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	188	0	0	0	0	0	0	0	0	0	188	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(7,765)	(158,754)	0	0	0	0	0	0	0	0	0	(166,519)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(18,358)	(158,754)	0	0	0	0	0	0	0	0	0	(177,112)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 **Report Period Beginning:** MAY 1, 1999 **Ending:** APRIL 30, 2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	6,776	0	0	0	0	0	0	0	0	0	6,776	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	1,558	0	0	0	0	0	0	0	0	0	1,558	32
33	Real Estate Taxes	0	84	0	0	0	0	0	0	0	0	0	84	33
34	Rent-Facility & Grounds	0	12,453	0	0	0	0	0	0	0	0	0	12,453	34
35	Rent-Equipment & Vehicles	(225)	2,803	0	0	0	0	0	0	0	0	0	2,578	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(225)	23,674	0	0	0	0	0	0	0	0	0	23,449	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	(1,667)	0	0	0	0	0	0	0	0	0	0	(1,667)	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(1,667)	0	0	0	0	0	0	0	0	0	0	(1,667)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(20,250)	(135,080)	0	0	0	0	0	0	0	0	0	(155,330)	45

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: MAY 1, 1999 Ending: APRIL 30, 2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Owner's Listing						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		17	Administrative	$ 416,060	Hunter Care Centers	100.00%	$ 143,215	$ (272,845)	1
2	V		19	Professional Fees				19,352	19,352	2
3	V		20	Due & Subscriptions				983	983	3
4	V		21	Clerical & General Office				43,493	43,493	4
5	V		22	Employee Benefits				22,146	22,146	5
6	V		23	Education & Training				96	96	6
7	V		24	Travel & Seminar				27,833	27,833	7
8	V		26	Insurance - Property				188	188	8
9	V		30	Depreciation				6,776	6,776	9
10	V		32	Interest				1,558	1,558	10
11	V		33	Real Estate Taxes				84	84	11
12	V		34	Rent - Leases				12,453	12,453	12
13	V		35	Equipment Rental				2,803	2,803	13
14	Total				$ 416,060			$ 280,980	$ * (135,080)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: MAY 1, 1999 Ending: APRIL 30, 2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: MAY 1, 1999 Ending: JUNE 30, 2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Hunter Care Center, Inc.
Street Address: 5895 Shiloh Road, Suite 104
City / State / Zip Code: Alpharetta , GA 30005
Phone Number: (678-296-4486
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Patient Days	210,674		$ 679,066	$ 678,954	44,425	$ 143,195	1
2	19	Professional Fees	Patient Days	210,674		91,760		44,425	19,350	2
3	20	Due & Subscriptions	Patient Days	210,674		4,661		44,425	983	3
4	21	Clerical & General Office	Patient Days	210,674		206,228		44,425	43,487	4
5	22	Employee Benefits	Patient Days	210,674		105,009		44,425	22,143	5
6	23	Education & Training	Patient Days	210,674		456		44,425	96	6
7	24	Travel & Seminar	Patient Days	210,674		131,972		44,425	27,829	7
8	26	Insurance - Property	Patient Days	210,674		890		44,425	188	8
9	30	Depreciation	Patient Days	210,674		32,128		44,425	6,775	9
10	32	Interest	Patient Days	210,674		7,387		44,425	1,558	10
11	33	Real Estate Taxes	Patient Days	210,674		399		44,425	84	11
12	34	Rent - Leases	Patient Days	210,674		59,048		44,425	12,452	12
13	35	Equipment Rental	Patient Days	210,674		13,290		44,425	2,802	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,332,294	$ 678,954		$ 280,942	25

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: MAY 1, 1999 Ending: APRIL 30, 2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	GMAC		X	Mortage	$62,503.00	4/14/99	$ 8,122,000	$ 8,041,339	5/1/2003	0.0825	$ 668,820	1
2	Magna Bank		X	First Mortgage	$42,038.00	3/96	4,482,465	Paid in Full	4/30/99			2
3			X	Second Mortgage	$14,000.00	3/96	1,529,064	Paid in Full	4/30/99			3
4												4
5												5
	Working Capital											
6	DVI		X	Working Capital	N/A	4/30/99	527,903	527,903	5/1/2003	Floating	10,341	6
7	First America		X	Working Capital	N/A	12/01/91	623,030	Paid in Full	4/30/99			7
8												8
9	TOTAL Facility Related				$118,541.00		$ 15,284,462	$ 8,569,242			$ 679,161	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 15,284,462	$ 8,569,242			$ 679,161	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: MAY 1, 1999 Ending: APRIL 30, 2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	115,510	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	44,468	2
3. Under or (over) accrual (line 2 minus line 1).	$	(71,042)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	137,339	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	66,297	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	57,369	8
	1996	59,447	9
	1997	146,846	10
	1998	96,857	11
	1999	98,037	12

1998 - 39,302
1999 - 98,037

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: MAY 1, 1999 Ending: APRIL 30, 2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,372 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 271,688 2. Number of Years Over Which it is Being Amortized: 4 YEARS

3. Current Period Amortization: 67,922 4. Dates Incurred: 4/30/99

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY GROUNDS	5 ACRES	1996	$ 94,000	1
2					2
3	TOTALS	#VALUE!		$ 94,000	3

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: MAY 1, 1995 Ending: APRIL 30, 2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	148		1996	1971	$ 3,712,783	$ 182,045	40	$ 182,045	$	$ 449,063	4
5			1996		370,000	18,500	20	18,500		77,083	5
6											6
7											7
8											8
	Improvement Type**										
9	BUILDING IMPROVEMENT			1996	22,679	2,729	5 - 10 YRS	2,729		9,978	9
10	BUILDING IMPROVEMENT			1997	18,552	2,424	5-10 YRS	2,424		8,051	10
11	WINDOWS (3)			1997	310	31	10	31		87	11
12	AIR CONDITION UNIT REPAIRS			1997	363	73	5	73		206	12
13	SWITCH AND HEATER ELEMENTS			1997	1,273	127	10	127		334	13
14	WALK IN COOLER REPAIRS			1999	2,432	270	3	270		540	14
15	HEATING REPAIRS			1999	1,567	87	3	87		174	15
16	ADJUST ASSETS & ACCUM. DEPRECIATION TO B/S 2000			2000	2,549				1,226	1,226	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 4,132,508	$ 206,286		$ 206,286	$ 1,226	$ 546,742	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: MAY 1, 1999 Ending: APRIL 30, 2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 253,015	$ 35,371	$ 35,371	$	VARIOUS	$ 144,214	37
38	Current Year Purchases							38
39	Fully Depreciated Assets							39
40	CORPORATE ALLOCATION		6,776	6,776				40
41	TOTALS	$ 253,015	$ 42,147	$ 42,147	$		$ 144,214	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$	4,479,523	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	248,433	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$	248,433	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	1,226	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	690,956	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: MAY 1, 1999 Ending: PRIL 30, 20(

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ 16,607 Description: Detail to be provided
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: MAY 1, 1999 Ending: APRIL 30, 200

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER AIDE	104

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER AIDE	53

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies	160	320		480
3	Classroom Wages (a)	1,012	4,358		5,369
4	Clinical Wages (b)	455	2,258		2,713
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		400		400
9	TOTALS	$ 1,627	$ 7,335	$	$ 8,962
10	SUM OF line 9, col. 1 and 2 (e)	$ 8,962			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	8
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	4
2. From other facilities (f)	
TOTAL TRAINED	12

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A-3	hrs	$	1,746	$	82,923	$ 363	1,746	$ 83,286	1
2	Licensed Speech and Language Development Therapist	10A-3	hrs		311		17,588		311	17,588	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	10A-3	hrs		2,389		102,926		2,389	102,926	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39-3	# of prescrpts				132,307			132,307	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): RESPIRATORY	10A-3			6,429		273,730		6,429	273,730	13
14	TOTAL			$	10,875	$	609,474	$ 363	10,875	$ 609,837	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: MAY 1, 1999 Ending: APRIL 30, 2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of APRIL 30, 2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 3,063,689	$ (6,823,884)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	891,170	832,919	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance		535,882	6
7	Other Prepaid Expenses		86,192	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Sec.Dep./Non compete	25,715		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,980,574	$ (5,368,891)	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		95,010	12
13	Land	94,000		13
14	Buildings, at Historical Cost	3,712,783		14
15	Leasehold Improvements, at Historical Cost	419,725	70,492	15
16	Equipment, at Historical Cost	253,015	852,291	16
17	Accumulated Depreciation (book methods)	(690,956)	(484,221)	17
18	Deferred Charges		792,224	18
19	Organization & Pre-Operating Costs	317,058	1,272,017	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(148,863)		20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Goodwill	1,635,000	14,665	22
23	Other(specify): Parent Co. Investment	3,137,618	26,657,125	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 8,729,380	$ 29,269,603	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,709,954	$ 23,900,712	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 936,138	$ 2,206,164	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,726		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	123,636	1,680,718	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	137,339	325	32
33	Accrued Interest Payable	75,330	397,943	33
34	Deferred Compensation		325,552	34
35	Federal and State Income Taxes		13,400	35
	Other Current Liabilities(specify):			
36	Accrued Accounting	13,507	56,678	36
37	Accrued State Assessments	6,438	970	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,301,114	$ 4,681,750	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	527,903	17,715,325	39
40	Mortgage Payable	8,122,000		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Intercompany Liabilities	2,518,827		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 11,168,730	$ 17,715,325	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 12,469,844	$ 22,397,075	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 240,110	$ 1,503,637	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,709,954	$ 23,900,712	48

***(See instructions.)**

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: MAY 1, 1999 Ending: PRIL 30, 200

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,009,933	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,009,933	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(769,745)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	(78)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (769,823)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 240,110	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: MAY 1, 1999 Ending: APRIL 30, 2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,582,522	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,582,522	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	52,835	6
7	Oxygen	327	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 53,162	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,667	12
13	Barber and Beauty Care	1,238	13
14	Non-Patient Meals	5,640	14
15	Telephone, Television and Radio	1,930	15
16	Rental of Facility Space		16
17	Sale of Drugs	373	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	51,940	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 62,788	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Rental/Dial a Ride**	1,315	28
28a	**Other Revenue/Late Fees**	1,406	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,721	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,701,193	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	795,424	31
32	Health Care	2,053,879	32
33	General Administration	1,175,485	33
	B. Capital Expense		
34	Ownership	1,139,246	34
	C. Ancillary Expense		
35	Special Cost Centers	225,874	35
36	Provider Participation Fee	81,030	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,470,938	40
41	**Income before Income Taxes (line 30 minus line 40)****	(769,745)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (769,745)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: MAY 1, 1999 Ending: APRIL 30, 2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,932	2,018	$ 36,954	$ 18.31	1
2	Assistant Director of Nursing	1,999	2,087	34,916	16.73	2
3	Registered Nurses	6,955	7,260	112,803	15.54	3
4	Licensed Practical Nurses	30,717	32,068	371,457	11.58	4
5	Nurse Aides & Orderlies	83,790	87,475	656,934	7.51	5
6	Nurse Aide Trainees	1,290	1,346	8,253	6.13	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,136	3,397	27,712	8.16	8
9	Activity Director					9
10	Activity Assistants	4,745	5,147	34,156	6.64	10
11	Social Service Workers	3,810	4,057	35,064	8.64	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,463	28,450	197,444	6.94	15
16	Dishwashers					16
17	Maintenance Workers	3,704	3,934	36,483	9.27	17
18	Housekeepers	12,375	13,594	80,338	5.91	18
19	Laundry	7,911	8,680	50,491	5.82	19
20	Administrator	1,810	1,894	42,600	22.49	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,901	8,272	82,221	9.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	7,803	8,169	79,677	9.75	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	206,341	217,848	$ 1,887,503 *	$ 8.66	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	220	$ 8,335	1-3	35
36	Medical Director		9,000	9-3	36
37	Medical Records Consultant	200	8,018	10-3	37
38	Nurse Consultant	1,020	28,727	10-3	38
39	Pharmacist Consultant	164	6,038	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	41	1,832	11-3	44
45	Social Service Consultant	41	1,832	12-3	45
46	Other(specify)				46
47	Medicare Coordinator Consultant	305	8,604	10-3	47
48	Rebursement Consultant	72	7,228	21-3	48
49	TOTAL (lines 35 - 48)	2,063	$ 79,614		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: MAY 1, 1999 Ending:APRIL 30, 2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Naomi Gates	Administrator	0	$ 42,600
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 42,600

B. Administrative - Other

Description	Amount
HO Acct. Office Allocation	$ 101,777
HO. Corporate Allocation	239,144
HO Regional Office Allocation	75,139
TOTAL (agree to Schedule V, line 17, col. 3)	$ 416,060
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
	Legal	$ 7,239
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 7,239

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 95,420
Unemployment Compensation Insurance	38,047
FICA Taxes	141,525
Employee Health Insurance	177,101
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	60
Employee Vaccinations	1,505
Other Employee Benefit	1,850
Corporate Allocation	22,146
TOTAL (agree to Schedule V, line 22, col.8)	$ 477,654

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 368
Advertising: Employee Recruitment	15,152
Health Care Worker Background Check	631
(Indicate # of checks performed 63)	
Illinois Health Care Association	6,135
HPSI Fees	405
Misc. Dues and Fees	1,344
Marketing/Advertising	5,677
Corporate Allocation	983
Less: Public Relations Expense	(405)
Non-allowable advertising	(5,677)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 24,613

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Corporate Allocation	27,833
In-State Travel	13,506
Meals	2,197
Lodging	5,188
Seminar Expense	790
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 49,514

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: MAY 1, 1999 Ending: APRIL 30, 2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number MATTOON HEALTH CARE CENTER # 0041574 Report Period Beginning: MAY 1, 1999 Ending: APRIL 30, 2

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **6135**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **NO** If YES, have these costs
been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **N/A**
What was the average life used for new equipment added during this period? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **26,871** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **NO** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **NO** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **81,030**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **N/A** Has any meal income been offset against
related costs? **YES** Indicate the amount. $ **5,640**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel?
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N/A** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **NO**
Attach invoices and a summary of services for all architect and appraisal fees.